

Selected Health Funding in the American Recovery and Reinvestment Act of 2009

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Summary

The American Recovery and Reinvestment Act of 2009 (ARRA), the economic stimulus legislation signed into law on February 17, 2009 (P.L. 111-5), included supplemental FY2009 discretionary appropriations for biomedical research, public health, and other health-related programs within the Department of Health and Human Services (HHS). Generally, the appropriations are to remain available through September 30, 2010. P.L. 111-5 also incorporated new authorizing language to promote health information technology (HIT) and established a federal interagency advisory panel to coordinate comparative effectiveness research.

As enacted, ARRA included \$17.15 billion for community health centers, health care workforce training, biomedical research, comparative effectiveness research, HIT, disease prevention, and Indian health facilities. This report discusses the health-related programs and activities funded by ARRA and provides details on how the administering HHS agencies and offices are allocating, awarding, and spending the funds. It will be regularly updated as new information becomes available.

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Introduction

The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5), which the President signed into law on February 17, 2009, provided \$17.15 billion in supplemental FY2009 discretionary appropriations for biomedical research, public health, and other health-related programs within the Department of Health and Human Services (HHS). ARRA also included new authorizing language to promote the widespread adoption of electronic health records and other health information technology (HIT), and established a federal interagency advisory panel to coordinate comparative effectiveness research.

This report discusses the health-related programs and activities funded by ARRA and provides details on how the administering HHS agencies and offices are allocating and obligating the funds. ARRA funds were designated as emergency supplemental appropriations for FY2009. Unless otherwise specified in the law, the ARRA funds are to remain available for obligation through the end of FY2010 (i.e., September 30, 2010).

Most of the health-related programs and activities for which ARRA provided supplemental funds also receive funding in annual appropriations acts through regular procedures. HHS FY2009 appropriations were included in the Omnibus Appropriations Act, 2009 (P.L. 111-8), which was signed into law on March 11, 2009. The Consolidated Appropriations Act, 2010 (P.L. 111-117), signed on December 16, 2009, included HHS appropriations for FY2010. For more information, see CRS Report RL34577, *Labor, Health and Human Services, and Education: FY2009 Appropriations*; and CRS Report R40730, *Labor, Health and Human Services, and Education: Highlights of FY2010 Budget and Appropriations*.

Table 1 summarizes ARRA's discretionary health funding, by HHS agency and office. **Figure 1** shows the percentage distribution of the ARRA funds, by HHS agency and office. Two additional tables that appear at the end of this report provide more details on the ARRA funding. **Table 4** shows the ARRA health funding, by type of activity funded, and includes a comparison of the amounts provided in ARRA with the regular FY2009 and FY2010 appropriations and the FY2011 budget request. **Table 5** shows the obligation of ARRA funds, by type of activity funding, for FY2009 and FY2010.

As part of its efforts to ensure transparency and accountability in the use of ARRA funds, the Office of Management and Budget (OMB) issued detailed government-wide guidance for implementing ARRA and established a website, "Recovery.gov," which allows the public to track ARRA spending.¹ The guidance required each federal agency to establish a Recovery page on its existing website, linked to Recovery.gov, on which they must post all agency-specific information related to ARRA.²

In most cases, ARRA specified that the agency receiving funding had to submit an initial implementation plan before the funds could be obligated. Those plans are posted on the HHS Recovery Plans website.³ In addition, ARRA required that a report on the actual obligations, expenditures, and unobligated balances for each ARRA-funded activity be submitted by November 1, 2009, and each six months thereafter as long as funding remains available for obligation or expenditure.

¹ Executive Office of the President, Office of Management and Budget, *Initial Implementing Guidance for the American Recovery and Reinvestment Act of 2009*, Memorandum for the Heads of Departments and Agencies M-09-10, February 18, 2009, http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-10.pdf.

² HHS created a Recovery website at <http://www.hhs.gov/recovery>.

³ HHS implementation plans are at <http://www.hhs.gov/recovery/reports/plans/index.html>.

Table I. ARRA Discretionary Health Funding, by Agency/Office

(\$ millions)

| Agency/Office | Funding | Explanation |
|--|---------------|---|
| Health Resources and Services Administration (HRSA) | 2,500 | ARRA's funding for HRSA included \$1.5 billion for health center renovation and repair, \$500 million for health center operation grants and HIT acquisition, and \$500 million for the National Health Service Corps and other health workforce programs. |
| National Institutes of Health (NIH) | 10,000 | ARRA's funding for NIH included \$8.2 billion for scientific research; \$1.3 billion for non-federal research facility construction, renovation, and equipment; and \$500 million for NIH buildings and facilities. |
| Agency for Healthcare Research and Quality (AHRQ) | 1,100 | ARRA provided this funding for comparative effectiveness research. Of the total, \$300 million is for AHRQ, \$400 million was transferred to NIH, and \$400 million is to be allocated at the Secretary's discretion. |
| Indian Health Service (IHS) | 500 | ARRA's funding for IHS included \$415 million for Indian health care and sanitation facility construction, building maintenance and improvement, and medical equipment (including HIT); and \$85 million for HIT infrastructure development and deployment, including telehealth. |
| Office of the HHS Secretary (OS) | | |
| Office of the National Coordinator for Health Information Technology (ONC) | 2,000 | ARRA provided this funding for grants and other activities authorized by the HITECH Act. |
| Public Health and Social Services Emergency Fund (PHSSEF) | 50 | ARRA provided this funding for HHS cybersecurity. |
| Prevention and Wellness Fund | 1,000 | ARRA's funding for prevention and wellness included \$300 million for CDC's immunization program, \$650 million for prevention and wellness programs, and \$50 million for state programs to reduce health care-associated infections. |
| TOTAL | 17,150 | |

Source: Table prepared by CRS based on the ARRA text (P.L. 111-5).

Each ARRA grant recipient is required to submit to the funding agency a quarterly report that includes the following information: (1) the total amount of ARRA funds received, (2) the amount of ARRA funds received that have been expended on projects and activities, and (3) details about the funded project or activity, including an estimate of the number of jobs created and the number of jobs retained by the project or activity. ARRA requires that the information submitted by grantees be posted on the funding agency's Recovery website.

In addition to funding health-related programs and activities, ARRA included discretionary funds for human services programs administered by HHS. It provided \$100 million to the Administration on Aging (AoA) for senior nutrition programs authorized under Title III of the Older Americans Act, and gave \$5.15 billion to the Administration for Children and Families (ACF) for the Child Care and Development Block Grant, the Community Services Block Grant, and Head Start. For more information on those funds, see CRS Report RL33880, *Older Americans Act: Funding*; and CRS Report R40211, *Human Services Provisions of the American Recovery and Reinvestment Act*. Throughout this report, unless otherwise specified, all references to the Secretary refer to the HHS Secretary.

Health Centers

ARRA provided \$2 billion to the Health Resources and Services Administration (HRSA) for grants to health centers authorized under section 330 of the Public Health Service (PHS) Act. Of this total, \$1.5 billion is for the construction and renovation of health centers and the acquisition of HIT systems. The remaining \$500 million is for operating grants to health centers to increase the number of underinsured and uninsured patients who receive health care services at these facilities. The implementation plan for ARRA funding of health center capital projects is available on the HHS Recovery Plans website.⁴ For more information on health centers, see CRS Report RL32046, *Federal Health Centers Program*.

Infrastructure

HRSA allocated the \$1.5 billion for health center infrastructure as follows: \$862.5 million for Capital Improvement Program (CIP) grants to support the construction, repair, and renovation of over 1,500 health center sites nationwide, including purchasing HIT and expanding the use of electronic health records (EHRs); \$512.5 million for Facility Investment Program (FIP) grants to expand the capacity of health centers to provide primary and preventive health services; and \$125 million for HIT systems/networks grants to support electronic health information exchange.⁵ Almost 60% of these funds were obligated in FY2009 (see **Table 5**). There is no regular appropriation for health center infrastructure. However, some health centers receive facilities and equipment funds in congressionally directed (i.e., earmarked) spending.⁶

Patient Services

Of the \$500 million ARRA appropriation for health center operations, HRSA allocated \$157 million for New Access Point (NAP) grants to support health centers' new service delivery sites, and \$343 million for Increased Demand for Services (IDS) grants to increase health center staffing, extend hours of operations, and expand existing health care services. These funds, which were obligated in FY2009, supplemented the \$2.2 billion provided for health centers in FY2009 through regular appropriations (see **Table 4** and **Table 5**).

HRSA awarded NAP competitive grants to establish 126 new health centers located in 39 states, Puerto Rico, and American Samoa. The award amounts range from \$478,000 to \$1,300,000. IDS grants were awarded to 1,128 federally qualified health centers in all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories, based on a formula.⁷ The project period for all IDS grantees is limited to two years, from March 27, 2009, through March 26, 2011. The IDS funds are projected to create or retain approximately 6,400 jobs and provide care to an estimated additional 2.1 million patients, including 1 million uninsured people.⁸

⁴ <http://www.hhs.gov/recovery/reports/plans/healthcenterscapital.pdf>.

⁵ Details on each of the grant programs, including the CIP awards, are at <http://bphc.hrsa.gov/recovery/>.

⁶ HRSA's FY2009 appropriations included \$310 million in congressionally directed spending for health facilities, including funding for numerous specified health centers. The agency's FY2010 appropriations included \$338 million in earmarked funds for health facilities.

⁷ Under the formula, each health center received \$100,000 (base allocation) + \$6.00 per insured patient + \$19.00 per uninsured patient. Patient information is based on the CY2008 Uniform Data System (UDS) data.

⁸ Details on the allocation and impact of NAP and IDS grants, by state and grantee, are available on the HHS Recovery website at <http://www.hhs.gov/recovery/programs/index.html#Community>.

Health Workforce Programs

ARRA provided \$500 million to HRSA for health workforce programs authorized in the PHS Act. Of this total, \$300 million is for the National Health Service Corps (NHSC) recruitment and field activities (PHS Act Title III), \$75 million of which is to remain available through September 30, 2011. The remaining \$200 million is for the health professions programs authorized in PHS Act Title VII (health professions education) and Title VIII (nursing workforce development). Some of these funds may also be used to develop interstate licensing agreements to promote telemedicine (PHS Act section 330L).

National Health Service Corps

The NHSC program provides scholarships and student loan repayments for medical students, nurse practitioners, physician assistants, and others who agree to a period of service as a health care provider in a federally designated health professional shortage area (HPSA). NHSC clinicians may fulfill their service commitments in health centers, rural health clinics, public or nonprofit medical facilities, or within other community-based systems of care. ARRA stipulated that 80% of the NHSC funds be used for scholarships and loan repayments, and the remaining 20% for field operations, including recruitment, placements and assignments, and HPSA designations.⁹ In regular appropriations, the NHSC program received \$135 million for FY2009 and \$142 million for FY2010 (see **Table 4**). For more information, see CRS Report R40533, *Health Care Workforce: National Health Service Corps*.

Health Professions Education and Training

Health professions programs authorized under Title VII provide grants, scholarships and loans to students and professionals in medicine and allied health professions. Nursing workforce programs authorized under Title VIII provide similar types of assistance to nursing students and professionals. Of the \$200 million ARRA appropriation for health workforce programs, \$148.4 million has been allocated for programs that target medical and dental professionals in primary care, nurses, disadvantaged students, and others; \$50 million is for equipment grants to enhance the training of health professionals; and \$1.5 million has been applied toward the development of interstate licensure agreements that promote telemedicine.¹⁰ In regular appropriations, Title VII and Title VIII programs received a total of \$392 million for FY2009 and \$497 million for FY2010 (see **Table 4**). For more information, see CRS Report RS22438, *Health Workforce Programs in the Public Health Service Act (PHSA): Appropriations History, FY2001-FY2010*.

Biomedical and Behavioral Research

ARRA provided \$10.0 billion directly to the National Institutes of Health (NIH) for biomedical research and extramural research facilities, plus \$400 million more through a transfer from AHRQ for comparative effectiveness research (discussed below). Of the \$10.0 billion, the law provided \$8.2 billion to the Office of the Director for broad support of NIH scientific research, both extramural and intramural. Most of that funding, \$7.4 billion, was transferred to the NIH institutes and centers and the Common Fund in proportion to their regular appropriations. The

⁹ More details on the allocation of ARRA funding for the NHSC program are in the implementation plan at <http://www.hhs.gov/recovery/reports/plans/nhsc.pdf>.

¹⁰ A list of ARRA funding levels for individual health workforce programs is at <http://bhpr.hrsa.gov/recovery/>.

remaining \$800 million is being used at the Director's discretion, with an emphasis on short-term (two-year) projects, including \$400 million that may be used under the Director's flexible research authority. Also included in the \$10.0 billion total was \$1 billion to the National Centers for Research Resources (NCRR) for grants to construct and renovate university research facilities, as well as \$300 million to NCRR for grants for shared instrumentation and other capital research equipment at extramural research facilities. Finally, the Buildings and Facilities account received \$500 million for construction, repair, and improvement of NIH intramural facilities.

NIH received a program level total of \$30.3 billion in regular FY2009 appropriations and \$30.9 billion in FY2010 appropriations. The additional funds from ARRA, which are being obligated at roughly \$5 billion in each of the two years, have therefore boosted NIH resources by about one-sixth each year. The \$8.2 billion in ARRA research funding is being used by the institutes and centers and the Director for a wide variety of competitive grant programs, as is the case with the regular appropriations. The intent, however, is to "follow the spirit of the ARRA by funding projects that will stimulate the economy, create or retain jobs, and have the potential for making scientific progress in 2 years." The \$1 billion for NCRR construction and renovation grants for extramural research facilities is being spent under a program that has received no regular funding since FY2005, while the \$300 million for shared instrumentation grants is several times larger than the usual funding for that program (see **Table 4**).

NIH activities with ARRA funding are being tracked on the NIH Recovery website, which includes links to news releases, information on current grant funding opportunities, awards already made, and ARRA-funded job postings at NIH.¹¹ NIH's ARRA implementation plans for the various funding categories are available on the HHS Recovery Plans website.¹² NIH is focusing activities on (1) funding new and recently peer-reviewed, highly meritorious research grant applications that can be accomplished in two years or less; (2) giving targeted supplemental awards to current grants to push research forward; and (3) supporting a new initiative called the NIH Challenge Grants in Health and Science Research for research on specific topics that would benefit from significant two-year jumpstart funds (grants have budgets under \$500,000 per year). Another new program, called Research and Research Infrastructure "Grand Opportunities" (GO) grants, will devote about \$200 million to large-scale research projects (budgets over \$500,000 per year) that work in areas of specific knowledge gaps, create new technologies, or develop new approaches to multi- and interdisciplinary research teams.

On September 30, 2009, President Obama spoke about the nearly \$5 billion that NIH had awarded in ARRA funding in FY2009, supporting over 12,000 grants to research institutions in every state (see **Table 5**). A White House press release highlighted examples of research in cancer, heart disease, and autism, particularly over \$1 billion in research applying the technology produced by the Human Genome Project.¹³ On February 1, 2010, NIH released actual FY2009 spending in 218 major research, disease, and condition categories, including the amounts

¹¹ The main site, "NIH and the ARRA," is at <http://www.nih.gov/recovery>. The "Recovery Act Grant Information" page is at <http://grants.nih.gov/recovery>, including a listing of funding opportunity announcements and searchable state-by-state data on ARRA-funded awards. ARRA-funded NIH jobs may be searched at <http://www.jobs.nih.gov/recovery>.

¹² See the section on "Strengthening Scientific Research and Facilities" at <http://www.hhs.gov/recovery/reports/plans/index.html>.

¹³ See the press release, "President Obama Announces Recovery Act Funding for Groundbreaking Medical Research," and an accompanying fact sheet, at http://www.whitehouse.gov/the_press_office/President-Obama-Announces-Recovery-Act-Funding-For-GroundingBreaking-Medical-Research/ and http://www.whitehouse.gov/the_press_office/Fact-Sheet-Recovery-to-Discovery-5-Billion-Recovery-Act-Investment-in-Scientific-Research-and-Jobs/.

provided under ARRA. Spending estimates for FY2010, FY2010 ARRA (partial), and FY2011 are also available.¹⁴

Comparative Effectiveness Research

ARRA provided \$1.1 billion to the Agency for Healthcare Research and Quality (AHRQ) for comparative effectiveness research (CER), also referred to as patient-centered health research. These funds are to be used to support research that (1) compares the clinical outcomes, effectiveness, and appropriateness of preventive, diagnostic, and therapeutic items, services, and procedures; and (2) encourages the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data. Of the total amount of funding provided, \$300 million is for AHRQ to invest in CER activities, \$400 million was transferred to NIH, and \$400 million is to be allocated at the discretion of the Secretary. ARRA also stipulated that AHRQ could use no more than 1% of the \$300 million under its own discretion for additional FTEs. According to the agency, that amount (i.e., \$3 million) provides sufficient funding to hire approximately 15 FTEs (two-year appointments).

The \$1.1 billion that ARRA provided for CER represents a substantial increase in federal research funding in this area. In its regular appropriations, AHRQ received \$50 million in FY2009 for CER, and \$21 million in FY2010. The agency's FY2011 budget request includes \$286 million for CER (see **Table 4**). AHRQ's research on comparative effectiveness is authorized by Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) and is part of the agency's Effective Health Care Program.

ARRA instructed the Secretary to contract with the Institute of Medicine (IOM) to produce a report with recommendations on national CER priorities. IOM released its report on June 30, 2009.¹⁵ Reflecting broad stakeholder input, the IOM report identified 100 health topics as high-priority areas for CER. Almost one-quarter of the priority topics address the health care delivery system. They include topics related to dissemination of CER study results; patient decision making; health behavior and care management; comparing settings of care; and utilization of surgical, radiological, and medical procedures. The IOM concluded that the country needs a robust CER infrastructure to sustain the research well into the future, including carrying out the research recommended in the report and studying new topics identified by future priority setting.

In addition, ARRA established an interagency advisory panel to help coordinate and support CER. The Federal Coordinating Council for Comparative Effectiveness Research, composed of senior officials from federal agencies with health-related programs, was instructed to submit an initial report describing current federal CER activities and providing recommendations for future research. Thereafter, the council is to prepare an annual report on its activities and include recommendations on infrastructure needs and coordination of federal CER. Importantly, ARRA included language stating that (1) the council may not mandate coverage, reimbursement, or other policies for public and private payers of health care; and (2) council reports and recommendations may not be construed as mandates or clinical guidelines for payment, coverage, or treatment.

¹⁴ See the table on "Estimates of Funding for Various Diseases, Conditions, and Disease Categories (RCDC)" at <http://www.report.nih.gov/rcdc/categories>.

¹⁵ Institute of Medicine, 2009, *Initial National Priorities for Comparative Effectiveness Research*, Washington, DC: The National Academies Press, <http://www.iom.edu/Reports/2009/ComparativeEffectivenessResearchPriorities.aspx>.

The council published its initial report on June 30, 2009.¹⁶ The report's recommendations focused on (1) the importance of disseminating CER findings to doctors and patients; (2) targeting CER to the needs of priority populations such as racial and ethnic minorities, and persons with multiple chronic conditions; (3) researching high-impact health arenas such as medical and assistive devices, surgical procedures, and behavioral interventions and prevention; and (4) electronic data networks and exchange.

Three implementation plans for ARRA-funded CER—one for funds to be obligated by AHRQ, a second for the NIH funds, and a third for the funds to be allocated at the discretion of the Secretary—are available on the HHS Recovery Plans website.¹⁷ While NIH obligated almost half of its ARRA funds for CER in FY2009, with the remainder to be obligated in FY2010, almost all of the ARRA funds for CER that are to be obligated by AHRQ or at the discretion of the Secretary will be awarded in FY2010 (see **Table 5**). AHRQ has published 11 CER funding announcements for ARRA funds to date; these announcements are available on AHRQ's website.¹⁸

Health Information Technology

ARRA provided \$2 billion to the HHS Office of the National Coordinator for Health Information Technology (ONC) to fund activities and grant programs authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was incorporated in ARRA. Of that amount, \$300 million is to support regional health information exchange networks. In addition, the Secretary was instructed to transfer \$20 million to the National Institute of Standards and Technology (NIST) for HIT standards analysis and testing. An implementation plan that discusses ONC's administrative and regulatory responsibilities under ARRA is available on the HHS Recovery Plans website.¹⁹ ONC received \$61 million in regular appropriations in both FY2009 and FY2010 (see **Table 4**). Details of the allocation and obligation of ARRA funds for the various HITECH Act grant programs are provided below, following a brief overview of the HITECH Act.

The HITECH Act is intended to promote the widespread adoption of HIT for the electronic sharing of clinical data among hospitals, physicians, and other health care providers.²⁰ To that end, the HITECH Act included the following provisions. First, it codified ONC within the Office of the HHS Secretary. Created by a presidential executive order in 2004, ONC has played an important role directing HIT activities both inside and outside the federal government. It has focused on developing technical standards necessary to achieve interoperability among varying EHR applications; establishing criteria for certifying that HIT products meet those standards; ensuring the privacy and security of electronic health information; and helping facilitate the creation of prototype health information networks. The goal is to develop a national capability to

¹⁶ HHS, Federal Coordinating Council for Comparative Effectiveness Research, *Report to the President and the Congress*, June 30, 2009, <http://www.hhs.gov/recovery/programs/cer/cerannualrpt.pdf>.

¹⁷ See the section on "Supporting Comparative Effectiveness Research" at <http://www.hhs.gov/recovery/reports/plans/index.html>.

¹⁸ AHRQ and the Recovery Act at <http://www.ahrq.gov/fund/cefarr.htm>.

¹⁹ See the section on "Accelerating the Adoption of Health Information Technology" at <http://www.hhs.gov/recovery/reports/plans/index.html>.

²⁰ The HITECH Act appears in two ARRA titles. Division A, Title XIII includes the provisions dealing with (1) ONCHIT, standards and certification; (2) grant, loan, and demonstration programs; and (3) privacy and security. Division B, Title IV includes the Medicare and Medicaid HIT incentives.

exchange standards-based health care data in a secure computer environment. The HITECH Act required the HHS Secretary, by December 31, 2009, to issue a comprehensive set of interoperability standards and certification criteria for EHRs.²¹

Second, the HITECH Act established six grant programs to provide funding for investing in HIT infrastructure, purchasing certified EHRs, training, and disseminating information on best practices, among other things (see below). Third, the HITECH Act authorized HIT incentive payments under the Medicare and Medicaid programs. Beginning in 2011, the Medicare program will begin providing bonus payments to doctors and hospitals that adopt and use certified EHRs in such a way as to improve the quality and coordination of health care. Those incentive payments are phased out over time and replaced by financial penalties for physicians and hospitals that are not using certified EHRs. The HITECH Act also provides for a 100% federal match for payments to certain qualifying Medicaid providers who acquire and use certified EHR technology.²²

Finally, the HITECH Act included a series of privacy and security provisions that amended and expanded the current federal standards under the Health Insurance Portability and Accountability Act (HIPAA). Among other things, it established a breach notification requirement for health information that is not encrypted, strengthened enforcement of the HIPAA standards, placed new restrictions on marketing activities by health plans and providers, and created transparency by allowing patients to request an audit trail showing all disclosures of their electronic health information. For more information, see CRS Report R40161, *The Health Information Technology for Economic and Clinical Health (HITECH) Act*.

HITECH Act Grants

As noted above, ARRA included \$2 billion in supplemental funding for the new HIT grant programs authorized under the HITECH Act. The allocation of those funds among the various programs and the status of their obligations are briefly summarized below.

Health Information Technology Extension Program

ONC has allocated \$693 million of the ARRA funds for the Health IT Extension Program. Of that amount, \$643 million is for cooperative agreements to support approximately 60 to 65 Regional Extension Centers (RECs) each serving a defined geographic area. The RECs will offer technical assistance, training, and other support services to help physicians and other providers in the adoption and meaningful use of EHR systems. The RECs are expected to support at least 100,000 priority primary care providers in rural and other medically underserved areas. In February 2010, ONC announced the first cycle of awards providing \$375 million to create 32 RECs.²³ A second round of REC awards is anticipated in April 2010.

²¹ See Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, "Health Information Technology: Initial Set of Standards, Implementation Specification, and Certification Criteria for Electronic Health Record Technology; Interim Final Rule," *75 Federal Register* 2014-2047, January 13, 2010.

²² In January 2010, the Centers for Medicare and Medicaid Services published a proposed rule for implementing the EHR incentives program. See Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicare and Medicaid Programs: Electronic Health Record Incentive Program; Proposed Rule," *75 Federal Register* 1844-2011, January 13, 2010.

²³ The February 12, 2010 press release is at <http://www.hhs.gov/news/press/2010pres/02/20100212a.html>.

The remaining \$50 million of the funds allocated for the Health IT Extension Program will be used to establish a national Health Information Technology Research Center (HITRC) to foster collaboration among the RECs and with other stakeholders to identify and share best practices in EHR adoption, effective use, and provider support.²⁴

State Health Information Exchange Cooperative Agreement Program

ONC has allocated \$564 million for states and qualified state designated entities (SDEs) to facilitate electronic health information exchange (HIE) through the meaningful use of EHR systems. Legal, financial, and technical support is necessary to enable consistent, secure, statewide HIE across health care provider systems. The State HIE Cooperative Agreement Program will fund efforts at the state level to establish and implement appropriate governance, policies, and network services within the broader national framework to build capacity for connectivity between and among providers. States and SDEs will be required to match grant awards beginning in 2011. The first cycle of state HIE awards, announced in February 2010 along with the initial round of REC awards, provided a total of \$386 million to 34 states (or SDEs), the District of Columbia, Puerto Rico, and the U.S. territories to develop HIE capability.²⁵ In March 2010, a second round of state HIE awards was announced, providing a total of \$162 million to the remaining 16 states (or SDEs).²⁶

Health Information Technology Workforce Development Program

ONC has set aside a total of \$120 million for the Health IT Workforce Development Program to establish and/or expand education programs for training HIT professionals. The funds will be used to award grants under four separate programs.²⁷ Award announcements are expected soon. First, the Community College Consortia Program will provide approximately \$70 million in assistance through cooperative agreements with about five institutions of higher education to create or expand HIT training programs at about 70 community colleges throughout the nation. Community colleges funded under this initiative will establish intensive, non-degree training programs that can be completed in six months or less by individuals with appropriate prior education and/or experience. ONC expects the participating colleges collectively to establish training programs with the capacity to train at least 10,500 students annually to be part of the HIT workforce.

Second, the Curriculum Development Centers Program will provide approximately \$10 million in assistance through cooperative agreements with about five non-profit institutions of higher education to develop curriculum and instructional materials to enhance workforce training programs primarily at the community college level. Third, the Competency Examination Program will provide approximately \$6 million through a cooperative agreement to an institution of higher education to support the development and initial administration of a set of HIT competency examinations. Finally, the University-Based Training Program will provide approximately \$32 million in assistance through cooperative agreements with eight or more institutions of higher

²⁴ More information on the Health IT Extension Program, including a list of REC grantees and an interactive U.S. map showing the regions covered by the RECs, is available on the ONC website at <http://healthit.hhs.gov/programs/REC>.

²⁵ The February 12, 2010 press release is at <http://www.hhs.gov/news/press/2010pres/02/20100212a.html>.

²⁶ The March 15, 2010 press release is at <http://www.hhs.gov/news/press/2010pres/03/20100315a.html>. More information on the State HIE Cooperative Agreement Program, including a list of grantees, is available on the ONC website at <http://healthit.hhs.gov/programs/statehie>.

²⁷ More information on the Health IT Workforce Development Program is available on the ONC website at <http://healthit.hhs.gov/hitechgrants>.

education to establish programs for increasing the supply of individuals qualified to serve in specific HIT professional roles requiring university-level training.

Beacon Community Cooperative Agreement Program

ONC has allocated a total of \$235 million for the Beacon Community Program to strengthen the HIT infrastructure in the United States. Of that amount, \$220 will be provided in cooperative agreements with integrated health systems, consortia of health care providers, or government entities to build on existing infrastructure to support electronic HIE. The remaining \$15 million will be used to provide technical assistance to the grantees and evaluate the success of the program. Beacon Community awards are expected to be announced soon.²⁸

Strategic Health IT Advanced Research Projects (SHARP) Program

Finally, ONC has allocated \$60 million for the SHARP Program to fund research in areas where breakthrough advances are needed to address barriers to the widespread adoption of HIT. SHARP grantees will implement a research program in one of the following areas: (1) developing security and risk mitigation policies to build public trust in HIT; (2) harnessing HIT to support clinicians' decision making; (3) developing new applications and platforms for achieving electronic HIE; and (4) enhancing the secondary use of EHR clinical data to improve health care quality. SHARP awards are expected to be announced soon.²⁹

Disease Prevention

ARRA provided \$1 billion to the Secretary for a *Prevention and Wellness Fund*, for three specified activities: (1) \$300 million to the Centers for Disease Control and Prevention (CDC) for PHS Act "Section 317" immunization grants; (2) \$50 million for state activities to reduce health care-associated infections (HAIs); and (3) \$650 million for evidence-based clinical and community prevention and wellness programs that address chronic diseases.

Immunization Programs

On April 9, 2009, HHS announced the allocation of \$300 million in ARRA funds for the Section 317 immunization program to the existing 64 state, territorial, and municipal public health department grantees.³⁰ Funds were transferred to CDC, which administers the program, and were to be distributed as follows: \$200 million in specified amounts to each grantee; \$50 million for program operation grants for grantees to deliver vaccines and strengthen their immunization programs; and \$18 million for innovation grants to increase vaccination rates and improve reimbursement practices. The remaining \$32 million would be for immunization information, communication, education, and evidence development activities. Funds were to be obligated in both FY2009 and FY2010 (see **Table 4** and **Table 5**).

²⁸ More information on the Beacon Community Cooperative Agreement Program is available on the ONC website at <http://healthit.hhs.gov/beacon>.

²⁹ More information on the SHARP Program is available on the ONC website at <http://healthit.hhs.gov/sharp>.

³⁰ HHS, "Biden Announces \$2.3 Billion in Recovery Act Funds to Help Care for Children, Prevent Disease," press release, April 9, 2009, <http://www.hhs.gov/news>. Grantees are all 50 states (including the District of Columbia), all territories, and the cities of New York, Chicago, Philadelphia, Houston, and San Antonio. For a state by state list of ARRA Section 317 awards, go to <http://transparency.cit.nih.gov/RecoveryGrants/grant.cfm?grant=vaccines>.

Health Care-Associated Infections (HAIs)

Of the \$50 million in ARRA funds to reduce HAIs, HHS transferred \$40 million to CDC for grants to state health departments to improve hospital infection control practices, and the remaining \$10 million to the Centers for Medicare and Medicaid Services (CMS) for state survey agency oversight of infection control practices in ambulatory surgical centers (ASCs).

On July 30, 2009, CMS announced that it was awarding \$1 million, distributed among 12 states, for onsite reviews of ASCs to ensure that the facilities are following Medicare health and safety standards, and that the remaining \$9 million would be available for all states in October 2009.³¹ On September 1, 2009, CDC announced plans to distribute the \$40 million to health departments in 49 states, the District of Columbia, and Puerto Rico, for the following HAI prevention activities: (1) creating or expanding state and local efforts to implement recommendations in the HHS HAI action plan; (2) increasing health care facilities' and health departments' use of CDC's National Healthcare Safety Network, an HAI surveillance system; (3) hiring and training of public health staff to promote and lead HAI prevention initiatives; and (4) complementing HAI investments from other HHS agencies.³² Funds were to be obligated in both FY2009 and FY2010 (see **Table 5**).

The Administration has noted that ARRA-funded CMS and CDC activities support a broader national strategy and action plan to reduce HAIs, published by HHS in January 2009.³³ Congress provided funding to HHS for a variety of HAI prevention activities in FY2009 and FY2010 appropriations, and HHS requests additional HAI funding for CDC and AHRQ activities for FY2011.³⁴ However, except for the ARRA funds, HHS has not generally presented comparable agency or departmental budget lines for HAI activities.

Evidence-Based Prevention and Wellness Programs³⁵

The majority of the \$650 million in ARRA funds for prevention and wellness programs is being administered by CDC. The agency notes that there are four program components, as presented in **Table 2**. For each component, funds are to be used by grantees to deliver evidence-based prevention strategies and programs for adults and children, utilizing local resources and strengthening state capacity for chronic disease prevention. Each component is intended to focus on the following prevention and wellness goals: (1) increase levels of physical activity; (2) improve nutrition; (3) decrease obesity rates; and (4) decrease smoking prevalence, teen smoking

³¹ CMS, "Recovery Act to Fund 12 State Efforts to Improve Care in Ambulatory Surgical Centers," press release, July 30, 2009. Information regarding states' use of funds for ASC surveys during FY2010 is available at CMS, ASC-HAI Initiative, Recovery Act FY2010 Plan Approvals, <http://www.cms.hhs.gov/Recovery/Downloads/FY2010ASCHAI.pdf>.

³² CDC, "CDC to Distribute \$40 Million in Recovery Act Funding to Help States Fight Healthcare-Associated Infections," press release, September 1, 2009, <http://www.cdc.gov/media>. See also CDC, "Healthcare-Associated Infections: Recovery Act," <http://www.cdc.gov/HAI/recoveryact/index.html>.

³³ HHS, *HHS Action Plan to Prevent Healthcare-Associated Infections*, January 2009, <http://www.hhs.gov/ophs/initiatives/hai/>.

³⁴ HHS, "Fiscal Year 2011 Budget In Brief," February 2009, pp. 33 and 49, <http://www.hhs.gov/asrt/ob/docbudget/2011budgetinbrief.pdf>.

³⁵ Unless otherwise noted, information in this section is drawn from CDC, "Recovery Act Communities Putting Prevention to Work," as of February 5, 2010, <http://www.cdc.gov/chronicdisease/recovery/index.htm>. See also HHS press releases, "HHS Secretary Sebelius Announces Cornerstone Funding of the \$650 Million Recovery Act Community Prevention and Wellness Initiative," September 17, 2009; and "\$120 Million for States Made Available as Part of Recovery Act Community Prevention and Wellness Initiative," September 29, 2009, both at <http://www.hhs.gov/news>.

initiation, and exposure to second-hand smoke. No funds for these activities were obligated in FY2009. As a result, according to the law, all of these funds must be obligated in FY2010 (see **Table 5**).

In its budget request for FY2011, HHS did not provide amounts for comparable activities in regular appropriations. The CDC National Center for Chronic Disease Prevention and Health Promotion conducts activities that are somewhat similar. There is a key difference, however, between CDC's annual chronic disease prevention appropriations and the ARRA prevention and wellness funding. Regular appropriations are generally provided for disease-specific activities,³⁶ whereas the ARRA funding was not designated for specific diseases. As noted earlier, ARRA funding goals instead target disease risk factors—often behavioral or lifestyle-based—that may predispose to multiple chronic conditions. As a result, ARRA prevention and wellness funding is not strictly comparable to activities funded through regular appropriations. Health reform proposals pending in the 111th Congress would establish mechanisms to provide annual baseline funding for similar prevention and wellness activities.³⁷ Also, in its FY2011 budget justification, CDC requests new appropriations language that would allow state grantees to reprogram up to 10% of funds from all CDC grants to carry out activities “to address one or more of the top six leading causes of death.” These causes are not defined.³⁸

Table 2. ARRA Evidence-Based Prevention and Wellness Program Funding
(\$ millions)

| Component | Description | Funding | Award Status |
|---|---|--------------|---|
| Community Initiative | Competitive grants to small and large cities, urban areas, and tribal communities for community approaches to prevention of obesity and tobacco use; administered by CDC. | 449.4 | Awards announced March 2010. ^a |
| States and Territories Policy and Environmental Change Initiative | Funding for states and territories for policy and environmental changes for chronic disease prevention and tobacco cessation; administered by CDC. | 125.0 | Awards announced Feb. 2010. ^b |
| States Chronic Disease Self-Management Initiative | Funding for state chronic disease self-management programs through existing aging network partnerships at state and community levels; administered by AoA. | 32.5 | Awards announced March 2010. ^c |
| National Prevention Media Initiative | National media initiative to complement state and community efforts; administered by CDC. | 40.0 | Funding opportunity not yet announced. |
| Management and Oversight | Administrative costs. | 3.0 | Not applicable. |
| TOTAL | | 650.0 | |

³⁶ For example, see the program activities table for Chronic Disease Prevention, Health Promotion, and Genomics in CDC, FY2011 Justification of Estimates for Congressional Committees, pp. 117-118, <http://www.cdc.gov/fmo/topic/Budget%20Information/index.html>.

³⁷ See “Sec. 2301. Prevention and Wellness” in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead, and “Sec. 4002. Prevention and Public Health Fund” in CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams.

³⁸ CDC, FY2011 Justification of Estimates for Congressional Committees, pp. 19-20, <http://www.cdc.gov/fmo/topic/Budget%20Information/index.html>.

Sources: Adapted by CRS from CDC, “Recovery Act Communities Putting Prevention to Work,” as of March 29, 2010, <http://www.cdc.gov/chronicdisease/recovery/index.htm>; and HHS, FY2011 Justification of Estimates for Congressional Committees, General Departmental Management, pp. 317-318, <http://www.hhs.gov/asrt/ob/docbudget/2011cj.pdf>.

Notes: Numbers do not add due to rounding. CDC is the Centers for Disease Control and Prevention. AoA is the Administration on Aging.

- a. HHS, “HHS Awards \$372 Million in Prevention and Wellness Grants to 44 Communities Around the Nation,” press release, March 19, 2010, <http://www.hhs.gov/news>. An additional amount of \$77 million is for technical assistance and evaluation activities associated with this program.
- b. HHS, “More Than \$119 Million Awarded to States and Territories,” press release, February 5, 2010, <http://www.hhs.gov/news>.
- c. HHS, “Secretary Sebelius Awards Funding for Chronic Disease Self-Management Programs for Older Americans,” press release, March 30, 2010, <http://www.hhs.gov/news>. Announced awards total \$27 million.

Indian Health Care

ARRA provided a total of \$500 million for the Indian Health Service (IHS)—\$415 million for IHS health facilities-related activities, including maintenance and improvement, and \$85 million for HIT activities. Within the health facilities account, IHS received \$227 million for health care facilities construction, \$100 million for facilities maintenance and improvement, \$68 million for sanitation facilities construction, and \$20 million for equipment (including HIT). The \$85 million IHS received for HIT activities, including funds for telehealth services,³⁹ were included in the IHS health services account but could also include HIT-related infrastructure activities. These funds were to be allocated at the discretion of the IHS director. As of January 29, 2010, IHS has obligated over 65% of these funds; the remaining funds will be obligated by the end of FY2010.⁴⁰ **Table 4** compares ARRA funding with regular IHS FY2009-FY2010 appropriations and FY2011-requested appropriations for the same activities.

Facilities Funding

IHS constructs, maintains, and operates hospitals, clinics, and health centers throughout Indian Country, and also funds construction of Indian sanitation facilities.

Health Care Facilities Construction

For health care facilities construction, ARRA required that the \$227 million be used to complete up to two facilities from IHS’s current priority list on which work had already begun. The facilities chosen are the Norton Sound Regional Hospital in Nome, AK, and the hospital and staff quarters at Eagle Butte Health Center in South Dakota.⁴¹ Both projects are expected to be completed by the fourth quarter of FY2012. As of January 29, 2010, approximately \$150 million

³⁹ Telehealth is the use of use of electronic information and telecommunications technologies, such as videoconferencing and the internet, to support long-distance clinical health care, health education and other health related activities. See <http://www.hrsa.gov/telehealth/>.

⁴⁰ U.S. Indian Health Service, “ARRA Briefing, Senate Committee on Indian Affairs, February 19, 2010,” transmitted to CRS Feb. 22, 2010; hereinafter, IHS ARRA Briefing.

⁴¹ HHS, American Recovery and Reinvestment Act, Strengthening Community Healthcare Services, *Indian Health Service: Health Care Facilities Construction*, <http://www.hhs.gov/recovery/reports/plans/ihshecfacilities.pdf> and http://www.ihs.gov/publicaffairs/PressReleases/index.cfm?module=view_details&ID=IyggMisK.

had been obligated, with an estimated 95 jobs created or saved as a result of the construction projects.⁴²

Facilities Maintenance, Sanitation Construction, and Equipment

Funds for facilities maintenance and improvement, sanitation, construction, and medical equipment were to be obligated in FY2009 and FY2010. Obligations for FY2009 through January 29, 2010 are included in **Table 3**. The table also includes information on the scheduled completion data of projects and estimates on the number of jobs created or saved as of the end of the first quarter of FY2010 (i.e., end of December 2009). For a list of the IHS construction projects and equipment, organized by state and type of project, see the HHS Recovery website, Tribal Pre-Award Funding by State.⁴³

Table 3. IHS ARRA Facilities Funding, by Type of Activity
(\$ millions)

| Funding Area | Total ARRA Funds | Use | Obligations ^a | Projection Completion Date | Jobs Created/Saved ^b |
|--|------------------|---|--------------------------|-----------------------------------|---------------------------------|
| Facilities Maintenance and Improvement | 100 | Funding for 302 infrastructure projects “to improve the condition, fire-life safety, energy conservation, and operational efficiency” of existing IHS and tribal health facilities. | 66 | End of FY2010 | 125 |
| Sanitation Construction | 68 ^c | Funding for 169 projects to provide water supplies, sewage disposal facilities, solid waste treatment site development, and technical assistance to Indian water and sewer utility organizations. | 48 | 4 th Quarter of FY2013 | 160 |
| Medical Equipment | 20 | Funding for 199 pieces of medical equipment, including \$5 million for 62 ambulances, and \$6.5 million for 19 computed tomography (CT) scanners. Equipment was allocated to locations prioritized within or across IHS’s 12 regions. | 10 | FY2011 ^d | na |

Sources: Table prepared by CRS based on HHS, American Recovery and Reinvestment Act, Strengthening Community Healthcare Services, *Indian Health Service: Maintenance & Improvement*, <http://www.hhs.gov/recovery/reports/plans/ihsfacilitiesmaintenanceimprovement.pdf>; HHS, American Recovery and Reinvestment Act, Strengthening Community Healthcare Services, *Indian Health Service: Sanitation Facilities Construction Program*, <http://www.hhs.gov/recovery/reports/plans/ihs-sanitation.pdf>; HHS, American Recovery and Reinvestment Act, Strengthening Community Healthcare Services, *Indian Health Service: Equipment*, <http://www.hhs.gov/recovery/>

⁴² IHS ARRA Briefing.

⁴³ <http://www.hhs.gov/recovery/programs/ihs/preawardfundingstate.html>.

reports/plans/ihsequipment.pdf; and U.S. Indian Health Service, “ARRA Briefing, Senate Committee on Indian Affairs, February 19, 2010,” transmitted to CRS Feb. 22, 2010.

- a. As of January 29, 2010.
- b. Based on grant recipient reports from the 1st quarter of FY2010 (i.e., end of December 2009).
- c. In addition to the ARRA funds directly appropriated to IHS, the Environmental Protection Agency transferred \$90 million for Sanitation Facilities Construction, for a total of \$158 million in ARRA funds.
- d. IHS estimates that all medical equipment purchasing will be completed within one year of final obligations (IHS ARRA Briefing.). Because IHS states that all obligations will be completed by September 30, 2010 (i.e., by the end of FY2010), all purchasing should be completed by the end of FY2011.

Health Information Technology Funding

IHS has existing HIT operations for both personal health services and public health activities, funded chiefly through the hospital and health clinics budget in IHS’s health services account. ARRA directed that the additional \$85 million in HIT funds be allocated by the IHS director. IHS distributed the HIT funds for the development of existing management and EHR software, and to telehealth infrastructure and development, with 20% allocated to hardware. IHS identified non-localized HIT projects, with \$61.4 million going for EHR development and deployment, \$2.45 million for personal health record development, \$16.96 million for telehealth and network infrastructure, and \$4.0 million for administration. Of the HIT funds, IHS obligated \$53.55 million as of January 29, 2010, with the remainder to be obligated by the end of FY2010.⁴⁴

Unlike the rest of HHS, IHS received its appropriations under ARRA’s title for Interior and Environment appropriations (Title VII). The provision for IHS facilities in Title VII excluded IHS health facilities funds from the Interior and Environment appropriations bill’s usual annual spending caps for medical equipment, and also excluded them from ARRA’s general provision requiring payment of prevailing wage rates under the Davis-Bacon Act for construction and repair projects. (Separate prevailing wage rate requirements apply to IHS construction activities.) ARRA report language for Title VII allowed agencies covered by the title to expend up to 5% of ARRA funds for administrative and support costs, but also noted that oversight of IHS activities under ARRA was to be included in the general oversight of HHS’s ARRA activities funded under ARRA’s title for HHS appropriations (Title VIII).

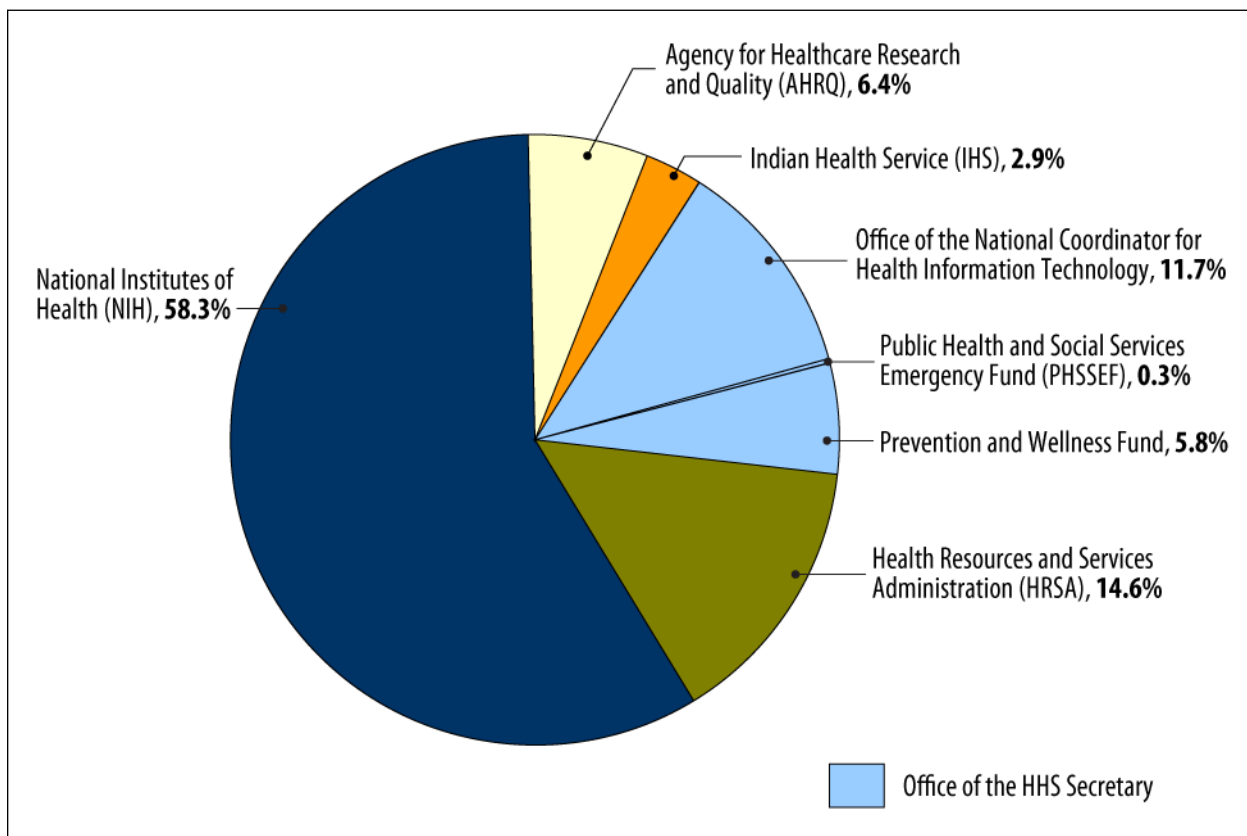
Further information on IHS’s ARRA expenditures, by project category, with links to more detailed implementation plans, is available on the HHS Recovery website.⁴⁵ For more on IHS appropriations in FY2009 and FY2010, see CRS Report R40685, *Interior, Environment, and Related Agencies: FY2010 Appropriations*. For general information on IHS, see CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*.

⁴⁴ IHS ARRA Briefing.

⁴⁵ <http://www.hhs.gov/recovery/programs/ihf/fundingdescription.html>.

Figure 1. ARRA Discretionary Health Funding, by Agency/Office

(Total funding = \$17.150 billion)



Source: Figure prepared by CRS based on the ARRA text (P.L. 111-5).

Table 4. ARRA Discretionary Health Funding and Comparable Appropriations, by Activity

(\$ millions)

| Activity (Agency/Office) | FY2009 Actual | FY2009 ARRA | FY2010 Enacted | FY2011 Request | Notes |
|--|---------------------|----------------|---------------------|---------------------|---|
| Health Centers (HRSA) | | | | | |
| Construction, renovation, HIT acquisition | 0 | 1,500 | 0 | 0 | There is no regular appropriation for health center infrastructure. Some facilities receive facility and equipment funds in congressionally directed (i.e., earmarked) spending. |
| Patient services | 2,190 | 500 | 2,190 | 2,480 | |
| Health Workforce (HRSA) | | | | | |
| National Health Service Corps | 135 | 300 | 142 | 169 | Of the \$300 million in ARRA funds for the NHSC, \$75 million is to remain available through the end of FY2011. Of the \$200 million in ARRA funds for health professions, \$1.5 million is being used to develop interstate licensing agreements to promote telemedicine. |
| Health professions | 392 | 200 | 497 | 503 | |
| Biomedical/Behavioral Research (NIH) | | | | | |
| Total, NIH funding | 30,254 ^a | 10,000 | 30,947 ^a | 31,947 ^a | Of the \$10 billion in ARRA funds for NIH, \$1.3 billion is for extramural research infrastructure, including laboratories and shared equipment; and \$500 million is for the construction and renovation of NIH facilities. The remaining \$8.2 billion is for scientific research activities (extramural and intramural) supported by all the NIH institutes and centers. |
| <i>Extramural facilities</i> | 0 | 1,000 | 0 | 0 | |
| <i>Shared instrumentation/equipment</i> | 64 | 300 | 64 | 66 | |
| <i>NIH buildings and facilities</i> | 126 | 500 | 100 | 126 | |
| Comparative Effectiveness (AHRQ, NIH, OS) | | | | | |
| Patient-centered health research | 50 | 1,100 | 21 | 286 | ARRA provided \$1.1 billion to AHRQ for comparative effectiveness research, of which \$400 million was transferred to NIH, and \$400 million is to be allocated at the Secretary's discretion. |
| Health Information Technology (OS) | | | | | |
| Office of the National Coordinator | 61 | 2,000 | 61 | 78 | ARRA provided \$2 billion to implement the HITECH Act, of which \$20 million was transferred to NIST for HIT standards analysis and testing. |
| Disease Prevention (OS, CDC, CMS, AoA) | | | | | |
| Immunization program | 560 | 300 | 562 | 579 | ARRA provided \$1 billion for a Prevention and Wellness Fund to be administered by the Secretary. Of the total, \$300 million was transferred to CDC for the immunization program, \$650 million is for prevention and wellness programs, and the remaining \$50 million is for state activities to reduce HAIs. For the prevention and wellness programs and the HAI activities there are no comparable funding figures in regular appropriations. |
| Prevention and wellness programs | na | 650 | na | na | |
| Health care-associated infections | na | 50 | na | na | |

| Activity (Agency/Office) | FY2009 Actual | FY2009 ARRA | FY2010 Enacted | FY2011 Request | Notes |
|--|------------------|----------------|-------------------|-------------------|---|
| Indian Health Care (IHS) | | | | | |
| Total, IHS facilities ^b | 390 | 415 | 395 | 445 | ARRA provided \$500 million for Indian health care, of which \$415 is for the construction of IHS facilities, building maintenance and improvement, water and wastewater sanitation projects, and the purchase of medical equipment. The remaining \$85 million is for HIT infrastructure development and deployment, including telehealth. |
| <i>Health care facilities construction</i> | 40 | 227 | 29 | 66 | |
| <i>Sanitary facilities construction</i> | 96 | 68 | 96 | 98 | |
| <i>Maintenance and improvement</i> | 54 | 100 | 54 | 56 | |
| <i>Medical equipment</i> | 22 | 20 | 23 | 24 | |
| Health information technology | 115 | 85 | 131 | 135 | |

Source: Table prepared by CRS based on the HHS FY2011 Budget in Brief, available at <http://www.hhs.gov/asrt/ob/docbudget/2011budgetinbrief.pdf>, and on the IHS FY2011 Justification of Estimates for Congressional Committees, available at <http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS%20FY%202011%20Congressional%20Justification.pdf>.

- a. Total NIH program level minus funds (\$300 million) for transfer to the Global Fund to Fight HIV/AIDS, TB, and Malaria.
- b. Totals for regular appropriations include activities that received no ARRA funds and are not shown here.

Table 5. Obligation of ARRA Discretionary Health Funding
(\$ millions)

| Activity (Agency/Office) | Total ARRA Funds | Obligations | |
|---|------------------------|-------------|--------|
| | | FY2009 | FY2010 |
| Health Centers (HRSA) | | | |
| Construction, renovation, HIT acquisition | 1,500 | 889 | 611 |
| Patient services | 500 | 497 | 3 |
| Total, Health centers | 2,000 | 1,386 | 614 |
| Health Workforce (HRSA) | | | |
| National Health Service Corps | 300 ^a | 66 | 159 |
| Health professions | 200 | 67 | 133 |
| Total, Health workforce | 500 | 133 | 292 |
| Biomedical/Behavioral Research (NIH) | | | |
| Scientific research | 8,200 | 4,607 | 3,593 |
| Extramural facilities | 1,000 | 52 | 948 |
| Shared instrumentation/equipment | 300 | 53 | 247 |
| NIH buildings and facilities | 500 | 50 | 450 |
| Total, Biomedical/behavioral research (excluding CER) | 10,000 | 4,762 | 5,238 |
| Comparative Effectiveness Research | | | |
| AHRQ | 300 | 5 | 295 |
| NIH | 400 | 192 | 208 |
| HHS-wide | 400 | 2 | 398 |
| Total, Comparative effectiveness research | 1,100 | 199 | 901 |
| Health Information Technology (OS) | | | |
| Office of the National Coordinator | 2,000 ^b | 1 | 1,919 |
| Disease Prevention (OS, CDC, CMS, AoA) | | | |
| Immunization program | 300 | 155 | 145 |
| Prevention and wellness programs | 650 | 0 | 650 |
| Healthcare-associated infections | 50 | 41 | 9 |
| Total, Disease Prevention | 1,000 | 196 | 804 |
| Indian Health Care (IHS) | | | |
| IHS buildings and facilities | 415 | 254 | 161 |
| Health information technology | 85 | 40 | 45 |
| Total, Indian health care | 500 | 294 | 206 |

Source: Table prepared by CRS based on the HHS FY2011 Budget in Brief, available at <http://www.hhs.gov/asrt/ob/docbudget/2011budgetinbrief.pdf>.

- a. Of the \$300 million for NHSC, \$75 million is to remain available through the end of FY2011.
- b. Funds are to remain available until expended.

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